Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 03/07/02.
   b. The request was received on 06/14/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC-60
   b. HCFA-1450
   c. EOBs/Retrospective Review
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC-60
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. The case file does not contain the additional information from the provider as required by Rule 133.307 (g) (3). The additional information was requested from the provider by the Division on 07/11/02. Without the provider's additional information, the Division cannot comply with Rule 133.307 (g) (4). The only response received from the carrier was received in the Division on 06/19/02 and is reflected in Exhibit II. All information in the medical dispute packet will be reviewed.

III. PARTIES' POSITIONS

1. Requestor: No Response

2. Respondent: No Response

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 03/07/02.

2. Per the provider's TWCC-60, the amount billed was $5,654.39; the amount paid was $519.00; the amount in dispute is $5,135.39.

3. The carrier denied the billed services by code, "OPSR –M – FAIR AND REASONABLE REIMBURSEMENT FOR THIS ENTIRE BILL IS MADE ON THE 'OR SERVICES' LINE ITEM." and "M – THE REIMBURSEMENT FOR THE SERVICES RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011 (B)." The retrospective review dated 05/07/02 denies additional payment based on a fair and reasonable denial.

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
03/07/02	None Listed	$5,654.39	$591.00	M	Unknown with no CPT codes listed	CPT descriptor; Rule 133.1 (a) (3) (C); Rule 133.307 (g) (3) (B), (C)	The provider's Table of Disputed Services fails to list correct CPT billing codes for the date of disputed service from the Commission fee guidelines as prescribed in Rule 133.1 (a) (3) (C). The provider failed to include any medical documentation to indicate that the service was rendered as billed. No additional reimbursement is recommended
Totals		$5,654.39	$591.00				The Requestor **is not** entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 15th day of November 2002.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm